the hospital, the name of the individual, and the dates and times the individual arrived at and was transferred (or discharged) from the hospital. The report provides expert medical opinion regarding whether the individual involved had an emergency medical condition, whether the individual's emergency medical condition was stabilized, whether the individual was transferred appropriately, and whether there were any medical utilization or quality of care issues involved in the case.

(vi) The report required under paragraph (g)(2)(v) of this section should not state an opinion or conclusion as to whether section 1867 of the Act or §489.24 has been violated.

(3) If a delay would jeopardize the health or safety of individuals or when there was no screening examination, the PRO review described in this section is not required before the OIG may impose civil monetary penalties or an exclusion in accordance with section 1867(d)(1) of the Act and 42 CFR part 1003 of this title.

(4) If the PRO determines after a preliminary review that there was an appropriate medical screening examination and the individual did not have an emergency medical condition, as defined by paragraph (b) of this section, then the PRO may, at its discretion, return the case to HCFA and not meet the requirements of paragraph (g) except for those in paragraph (g)(2)(v).

(h) *Release of PRO assessments.* Upon request, HCFA may release a PRO assessment to the physician and/or hospital, or the affected individual, or his or her representative. The PRO physician's identity is confidential unless he or she consents to its release. (See §§476.132 and 476.133 of this chapter.)

[59 FR 32120, June 22, 1994]

EFFECTIVE DATE NOTE: At 59 FR 32120, June 22, 1994, §489.24 was added. Paragraphs (d) and (g) contain information collection and recordkeeping requirements and will not become effective until approved by the Office of Management and Budget. A document will be published in the FEDERAL REGISTER once approval has been obtained.

§489.25 Special requirements concerning CHAMPUS and CHAMPVA programs.

For inpatient services, a hospital that participates in the Medicare program must participate in any health plan contracted under 10 U.S.C. 1079 or 1086 (Civilian Health and Medical Program of the Uniformed Services) and under 38 U.S.C. 613 (Civilian Health and Medical Program of the Veterans Administration) and accept the CHAMPUS/CHAMPVA-determined allowable amount as payment in full, less applicable deductible, patient cost-share, and noncovered items. Hospitals must meet the requirements of 32 CFR part 199 concerning program benefits under the Department of Defense. This section applies to inpatient services furnished to beneficiaries admitted on or after January 1, 1987.

[59 FR 32123, June 22, 1994]

§489.26 Special requirements concerning veterans.

For inpatient services, a hospital that participates in the Medicare program must admit any veteran whose admission is authorized by the Department of Veterans Affairs under 38 U.S.C. 603 and must meet the requirements of 38 CFR part 17 concerning admissions practices and payment methodology and amounts. This section applies to services furnished to veterans admitted on and after July 1, 1987.

[59 FR 32123, June 22, 1994]

§489.27 Beneficiary notice of discharge rights.

A hospital that participates in the Medicare program must furnish each Medicare beneficiary, or an individual acting on his or her behalf, the notice of discharge rights HCFA supplies to the hospital to implement section 1886(a)(1)(M) of the Act. The hospital must provide timely notice during the course of the hospital stay. For purposes of this paragraph, the course of the hospital stay may begin with the provision of a package of information regarding scheduled preadmission testing and registration for a planned hospital admission. The hospital must be